DETERMINATION OF DISABILITY
Authorization for Release of Medical Information

State Form 44554 (R3 / 9-03) / OMPP 3512

CONFIDENTIALITY STATEMENT

The personal information requested on this form will be used in the determination of your entitlement to, or continued receipt of, Medical Assistance administered by the Indiana Family and Social Services Administration. Disclosure of the information requested is **mandatory** pursuant to the provisions of IC 12-15 *et seq*. Non-disclosure of the information requested will hamper and possibly prevent the delivery of assistance to you. All personal information collected on and as authorized by this form will be treated as confidential pursuant to 470 IAC 1-2-7, 470 IAC 1-3-1, 42 CFR 431 Subpart F and 45 CFR 164 Subpart E.

NOTICE TO EXAMINING PHYSICIAN

By court order and federal regulation, if the client appeals the decision of the State Medicaid Medical Review Team, this medical information becomes available to the client or his/her legal representative.

DETERMINATION OF DISABILITY
Medical Information

Indiana Law [IC 12-14-15-1(2)] requires that, in order to be eligible for Medical Assistance to the Disabled, a person must have a physical or mental impairment, disease, or loss which appears reasonably certain to result in death or that has lasted or appears reasonably certain to last for a continuous period of at least twelve (12) months without significant improvement and which substantially impairs his/her ability to perform labor or services or to engage in a useful occupation. This is not the same definition of disability that is used by the Social Security Administration, or other agencies. The State Medicaid Medical Review Team will make the final disability determination. The records released pursuant to this authorization wil be used in making this determination.

PATIENT'S / APPLICANT'S CONSENT FOR RELEASE OF MEDICAL RECORD(S)

Date of birth of patient/applicant (*mo., day, yr.*)	Social Security number of patient/applicant	Case number	Date of consent (*month, day, year*)

I, _____
First name Middle initial Last name

_____
Address (*number and street, city, state, ZIP code)*

do hereby authorize _____
Name of person releasing information

_____
Organization releasing information

_____
Address of organization (*number and street, city, state, ZIP code*)

to release the following medical records:

☐ Entire medical record for the following dates (*month, day, year*) _____

☐ Portions of the medical record relating to psychiatric, psychological, or mental health counseling for the following dates (*month, day, year*) _____

(*If this authorization is for disclosure of records relating to psychiatric, psychological, or mental health counseling, it cannot be used as an authorization for any other type of medical record.*)

Copies of the records should be furnished to the: _____
Name of local office

_____
Address of local office (*number and street, city, state, ZIP code*)

I understand that this information is protected under Federal and State confidentiality and privacy regulations and cannot be disclosed without my written authorization unless otherwise provided for in the regulations.

I understand that, pursuant to IC 16-39-1-4, this consent for release of medical and mental health information is subject to revocation by me at any time, except to the extent that action has been taken in reliance on the consent. This consent will expire ninety (90) days from the consent date listed above unless otherwise waived by me, in writing, any time prior to the ninety (90) day expiration date.

Signature of applicant or legal representative	Date signed (*month, day, year*)
If patient is a minor, signature of parent or legal representative	Date signed (*month, day, year*)

DISTRIBUTION: White and Canary - Return in the attached envelope to the County Office of Family and Children; Pink - Retained by physician